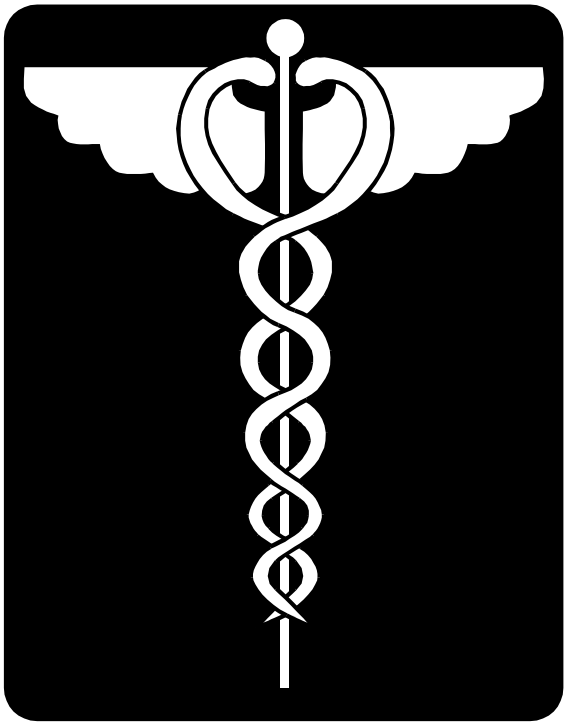
2003 Statewide Medical & Health Disaster Exercise

EXERCISE CONTACT TOOLKIT

State of California
Emergency Medical Services Authority



NOVEMBER 13, 2003

State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 13, 2003

Executive Summary

Dear Exercise Contact,

It is time again for the annual Statewide Medical and Health Disaster Exercise! This is California's 5th annual exercise, and we continue to expand the participants this year with local public health and local government. The last couple of years, the exercise has focused on those "man-made" disasters that confront emergency managers and the healthcare community. This year, the Exercise Planning Committee has designed the scenario to include the issues and challenges should a biological terrorism event occur in the State of California.

In evaluating the 2002 Statewide Medical and Health Disaster Exercise, participants were asked about conducting the exercise in "off hours". Approximately 83% of respondents replied that their facilities would be interested in an "off hours" exercise and 72% responded that the PM shift hours as number 1 priority. Therefore, the Exercise Planning Committee planned this year's exercise for the PM shift hours.

An off hours exercise may pose unique planning issues at the participant and local level. As the Operational Area (county) Exercise Contact you are the point of contact for planning, questions and organization for the exercise.

This year, the Exercise Planning Committee will be holding a conference call/meeting for the Exercise Contacts to discuss planning strategies and provide an opportunity to ask questions and share best practices. The conference call will take place on **Friday, August 20, 2003 from 2:00 pm until 4:30 pm**. The conference call in number and pass code will be emailed to the Exercise Contacts no later than August 13, 2003.

Important Timelines and Deadlines

August 20, 2003:	Operational Area Exercise Contact Orientation Conference Call from 2:00 pm until 4:30 pm. The call is intended to orient the Exercise Contacts to the exercise and assist with organization and planning for the exercise. Exercise Contacts will be notified of the conference call-in numbers.
September 13, 2003	Deadline for exercise participants to fax Intent to Participate Form (Exercise Guidebook, page 18) to the Operational Area Medical/Health Exercise Contacts.
September 26, 2003	Deadline for Operational Area Medical/Health Exercise Contacts to fax the Operational Area Intent to Participate (Exercise Guidebook, page 19) to the Regional Disaster Medical and Health Specialist (RDMHS). See the Exercise Guidebook, page 45 for a list of the RDMHS)
November 13, 2003	The exercise will be conducted from 1600 (4:00 p.m.) until 2000 (8:00 p.m.) The scenario stages the exposure event to occur on Sunday, November 9, 2003 and the healthcare system responds to overwhelming numbers of patients presenting with symptoms, building up to the beginning of the exercise.
November 14-27, 2003	Exercise Contact to conduct Operational Area hotwash/debriefing and provide this information to the RDMHS no later than November 28, 2003.
November 28, 2003	Deadline for participants to complete and mail the appropriate Master Answer Sheet (Exercise Guidebook, pages 20, 24 or 28) to the California EMS Authority (see address on form) to receive a participation certificate.

Thank you for your commitment to disaster medical planning and preparedness.
We look forward to hearing about your successful exercise!

State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 13, 2003

Exercise Contact Toolkit

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A GUIDE FOR MEDICAL/HEALTH OPERATIONAL AREA EXERCISE CONTACTS
November 13, 2003

The following materials are offered to assist you in your preparation for and execution of the exercise.

Pre-Exercise Checklist

Preparing the Materials
Compile, at a minimum, the following materials:

- 2003 Statewide Medical & Health Disaster Exercise Guidebook for November 13, 2003 from the Emergency Medical Services Authority, focusing on the following documents:
  - Exercise Objectives (Exercise Guidebook, page 2)
  - Background Scenario for Exercise (Exercise Guidebook page 6)
  - Exercise Day Scenario (Exercise Guidebook, page 10)
  - Intent to participate Forms (Exercise Guidebook, page 18 and 19)
  - Conducting the Exercise: Tips for Hospitals (Exercise Guidebook, page 32)

  Note: Supplies of the printed Exercise Guidebook are limited. For additional copies, please visit the website at www.emsa.ca.gov/dms2/hospambex.asp.

- Messages developed from the scenario to provide to the participants within the Emergency Operations Center (EOC) and messages for the Auxiliary Communications System groups within your OA.
- A list of key contact information for participants and government organizations.
- Critique forms developed by your organization and the "Hotwash/Debriefing Form" in this Exercise Contact Toolkit, (page 32).

Coordination with Other Organizations
This year, the exercise focuses on the medical and health system over a series of days as it responds to an outbreak of pneumonic plague. The background scenario sets the stage of events that have occurred before the actual exercise day begins, with the healthcare system responding to an overwhelming influx of patients and shortages of resources including staffing, supplies, equipment and medications.

Recommended Primary Contacts and Participants in the Operational Area

1. Each Exercise Contact is strongly encouraged to contact the following entities within the operational area no later than **September 13, 2003** to ascertain their participation in the exercise:
   - ❑ Hospitals and healthcare facilities
   - ❑ Ambulance Providers and Emergency Medical Services
   - ❑ Local Public Health Department
   - ❑ Local Emergency Medical Services Agency
   - ❑ Local Office of Emergency Services
   - ❑ Auxiliary Communications System (ACS) providers
   - ❑ Medical and Health Operational Area Coordinator (MHOAC)

2. Each entity participating in the exercise is encouraged to designate a representative to liaison with the Exercise Contact and attend meeting in preparations for the exercise.

3. The Exercise Contact is encouraged to conduct at least two (2) pre-exercise, preparatory meetings with the participants within your Operational Area (OA) to:
   - ❑ Determine level and scope of agency and OA participation and collaborate on the development of community specific scenario events based on the statewide scenario.
   - ❑ Provide participants with phone numbers to reach the Exercise Contact on the day of the exercise, as well as relevant fax and e-mail addresses.
   - ❑ Inform participants of potential conflicts or competing activities that may occur that day.
   - ❑ Communicate procedures to terminate the exercise both within the OA and within each participating entity, should an actual emergency occur during the exercise. Many agencies use the term "time out" to stop exercise play.
   - ❑ Identify where and how information is to be communicated within participating organizations during the exercise, and how it is to be marked, e.g., "This is a Test," "This is a Drill," or "This is an Exercise."
   - ❑ Identify the person (or agency) that will enter information into RIMS during the exercise.
   - ❑ Invite other participating agencies, departments or organizations to briefings or training for the exercise.
   - ❑ Contact and update other agencies, departments or organizations about any last-minute changes in participation or communications.
   - ❑ Assist the participants in finding community volunteers to participate in the exercise to increase realism in the play.

Other Recommended Contacts and Participants in the Operational Area

Expanding the exercise in your OA is strongly recommended and encouraged. The following entities should be considered for involvement in the exercise, if possible:

- ✓ MMRS (if applicable in the city/OA)
- ✓ Local law enforcement
- ✓ Local fire departments
- ✓ Local schools and/or school officials (even if only in a tabletop)
- ✓ Medical Examiner (Coroner)
- ✓ Environmental Health
- ✓ Public Utilities
- ✓ Others as identified by the scenario or the unique OA entities

Coordination with the Media
Collaborate with the local agencies'/department's Public Information Officer to define how the media will be addressed during the planning process (media or press releases), during the exercise (press briefings and conferences, written risk communication messages), and post exercise (communicating the success of your community-wide exercise). Prepare media releases in advance and sound bites can even be pre-recorded. For examples of Public Service Announcements and Media Advisories, see the Exercise Guidebook, page 17.

Scheduling Personnel, Space, and Equipment
It is recommended that facility and organization staff assigned to the exercise are notified well in advance to coordinate their schedules and plan for participation. For critical exercise positions or assignments, consider scheduling back-up staff that are also briefed and trained prior to the exercise.

- Announce the exercise date on local agencies/departments calendars, in-house publications or computer schedules so all involved personnel save the date when they are scheduling other activities.
- Identify and reserve the exercise location/space before the exercise.
- Assess the exercise area to make sure construction or other changes do not hinder the layout for performance of the exercise, e.g., removal of the phone lines from the room, or removal of the chairs and tables.
- Develop a checklist of the equipment you will need to support the exercise.
- Check all equipment for proper functioning and operation before the exercise.

Reporting Intent
Each participating entity should notify the Exercise Contact of its intent to participate and complete the "Intent to Participate" form (see page 18 in the 2003 Statewide Medical & Health Disaster Exercise Guidebook). This year, the "Intent to Participate" form does not ask for the level of exercise play in the organization, but only their intent to participate. The participating entity should fax the "Intent to Participate" form to the Exercise Contact by **September 13, 2003**. Upon receipt of the form, the Exercise Contact will compile the participant totals on the "Operational Area Intent to Participate" form (see page 19).

The Exercise Contact will fax the "Operational Area Intent to Participate" form to the Regional Disaster Medical Health Specialist (RDMHS) no later than close of business on **September 26, 2003**. (See page 31 in this toolkit or page 42 in the 2003 Statewide Medical & Health Disaster Exercise Guidebook for the listing of RDMHS contact and fax numbers).

Developing Local Scenarios
The scenario in the 2003 Statewide Medical & Health Disaster Exercise Guidebook details a sequence of events to be used by participants. This sequence provides the overall anticipated schedule of activities that all participants will incorporate into the community exercise. Local agencies and departments may plan an extended exercise scenario or alter the scenario to meet the needs of the OA or organization. Local agencies/departments will decide the scale and intensity of participation and their role in transmitting information from the healthcare providers to local government.

To assist hospital participants in planning and executing a facility-wide exercise, please see "Conducting the Exercise: Tips for Hospitals" in the Exercise Guidebook, page 32.

Recommended Exercise Day Activities

Pre-Exercise Survey of Resources
Changes often occur at the last minute and can interfere with a successful exercise. Organize a team of "checkers" who do nothing more than check facility readiness, materials, storage lockers, phones, fax machines and other communications systems the evening before and the morning of the exercise.

Briefing of Participants
Provide the participating staff job action sheets, background information, organizational charts, pertinent policies and procedures and role expectations before the exercise begins to increase participant comfort level and exercise success. At the minimum, the facility should be aware of the exercise in progress.

"This Is Only An Exercise!"
During the briefings, and throughout the exercise on November 13th, it is very important to stress that this is **only an exercise** to all participants and agencies/departments. Written materials and scripts should denote and emphasize this is only an exercise. Oral communications and instructions should reinforce the "exercise" status. This is a learning opportunity for the staff, the facility/organization and local government and can assist in assessing the effectiveness of the emergency management plan(s) and identify areas for improvement and refinement.

Terminating the Exercise for an Actual Emergency
Should there be a need to stop or "pause" the exercise due to an actual emergency situation or event, the State Exercise Control Cell will notify the RDMHS to terminate the exercise. The State Exercise Control Cell will give a "**Terminate the Exercise**" order and the exercise will be immediately terminated at the State and regional level. Each Operational Area Exercise Contact will be notified by the RDMHS to terminate the exercise.

It is recommended that the OA Exercise Contact **and** each participating organization establish a similar "Terminate the Exercise" command in the case of actual emergency or safety issue.

Reporting Situation/Status Information to the Operational Area (OA)
Each participating agency will compile situation and status information utilizing their own operational area forms and submit reports to the Operational Area officials according to OA policies.

The participants will begin transmitting their situation/status reports to the OA by 7:00 pm on the day of the exercise (see the exercise scenario).

RIMS: Reporting Operational Area Situation/Status into RIMS
Note: It is very important that the "**training**" section in RIMS is utilized to enter data during the exercise. When RIMS is accessed, be sure that you are in the TRAINING SECTION before data entry.

The Response Information Management System (RIMS) is an Internet based information management system and consists of a set of databases designed to collect information on the disaster situation, communicate action plans and receive mission requests. RIMS is accessed and utilized by operational areas, regional and State governmental agencies.

Important RIMS Tips and Considerations

- **RIMS Access Issues:**
  a. Established RIMS users have a password into RIMS and will log onto RIMS using their individual assigned access and password.
  b. If you do not have RIMS access, please contact Cheryl Starling at the EMS Authority at 916-322-4336 or cheryl.starling@emsa.ca.gov for a temporary exercise only password assignment and the procedure for obtaining RIMS access.
- RIMS classes will be scheduled in September and October. Please check the EMSA website at **www.emsa.ca.gov** or email **Cheryl.starling@emsa.ca.gov** for more information.
- The **RIMS Situation AND the RIMS Event Reports** will be entered into RIMS before the exercise by the State Exercise Control Cell, and should not be re-entered by the operational area or local governmental agency. This will ensure that all RIMS entries will be entered into the disaster exercise fields.
- Please enter RIMS information only under the ***Status Report*** Field, not the Event or Situation report field.
- The Event is named: ***2003 Medical and Health Disaster Exercise***. It is very important to enter the Operational Area RIMS information under this event name and not a similar exercise/event/name. Do not create a new name for the exercise, but enter all data under this event name only.

On the day of the exercise, November 13, 2003, the Operational Area will enter information into RIMS at the following intervals:

- Enter an initial status report **within one (1) hour of the beginning of the exercise**, or at approximately 5:00 pm. This initial report is a "snap-shot" of the status of and critical issues confronting the OA.
- Update and modify the initial report as additional information or resources are requested.
- Enter final exercise status information obtained from participants beginning at 7:00 pm or later, compiling the information and reporting aggregate data.

Essential initial status (or "snap-shot") **information** to be entered into RIMS should include:

- Hospital Status (RIMS Status Report Number 8.b.)
- Estimated Casualties: Major and Minor (RIMS Status Report Number 7.a and b.)
- Overall Medical/Health Critical Issues (RIMS Status Report Number 19)
- Bed Availability (RIMS Status Report, Bed Availability, Resources Available)

Expanded and ongoing status information to be entered into RIMS may include, but is not limited to:

- Hospital Status (RIMS Status Report Number 8.b.)
- Bed Availability for the next 8 and 24 hours (RIMS Status Report, Bed Availability, Resources Available)
- Estimated Casualties: Major and Minor (RIMS Status Report Number 7.a and b.)
- Status of SNF's, clinics and/or Field Treatment Sites (RIMS Status Report Number 9)
- Medical/Health Critical Issues (RIMS Status Report Number 19)
- Medical mutual aid needs for personnel, supplies and transport (RIMS Status Report Number 10)

Auxiliary Communications Systems (ACS)
The Exercise Contact should facilitate the involvement of local and OA ACS providers. Participating organizations may also plan on activating their ACS plans as communication system overload is planned in the exercise scenario.

Post-Exercise Critiques and Reporting
Exercise debriefings (critiques or "hotwashes") should be conducted by each participating agency and a community-wide debriefing scheduled and conducted by the OA Exercise Contact. To assist the debriefing, there is a "hot wash" (or debriefing points) in this Exercise Contact Toolkit (see page 32) to assist in the evaluation of the exercise. This "hot wash" information will also be needed for the regional and state "hot wash".

Considerations for "hot washes"/debriefings for the Exercise Contact include:

- Announce the debriefing meeting in advance of the exercise to facilitate participant attendance and preparation for the meeting.
- Distribute the hotwash/debriefing points in advance of the exercise to allow meeting participants to prepare critiques.
- Hold debriefing meetings in a convenient location in the community.
- Act as the facilitator and allow the participants from government and private sector organizations to discuss the successes, challenges and needed improvements identified during the exercise.
- Take meeting notes to be provided later to all participants as a feedback mechanism, including those participants who could not attend the critique.
- Develop a list of improvements needed and action items into three categories:
  - –Short Term (less than six weeks to accomplish)
  - –Mid Term (up to three months)
  - –Long Term (greater than three months)
- When possible, organize a work group to follow-up on the action items over the next three months,
- Remind exercise participants to complete the exercise evaluation answer sheets to receive a Certificate of Participation (see below).
- End the meeting on a high note and thank participants for their participation.

Participant Recognition
After the exercise, Certificates of Participation will be issued to all exercise participants upon return of the Exercise Evaluation "Master Answer Sheet" (see pages XX, XX and XX in the 2003 Statewide Medical and Health Disaster Exercise Guidebook) to:

Emergency Medical Services Authority
1930 9th Street
Sacramento, CA 95814
Attn: Disaster Exercise

Additional Information
Should the Exercise Contact wish to have other organizations or people who facilitated the exercise to receive recognition and a certificate of participation or certificate of leadership, please contact Cheryl Starling via email at cheryl.starling@emsa.ca.gov.

End Notes
If you have any questions or inquiries about the 2003 Statewide Medical & Health Disaster Exercise, please contact your Regional Disaster Medical/Health Specialist (RDMHS).

State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 13, 2003

BACKGROUND FOR THE SCENARIO

NOTE: The Statewide Medical and Health Disaster Exercise begins on November 13, 2003, at 4:00 p.m. This information is provided as scenario background to "set the stage" for the events leading up to the day of the exercise. The intention of the scenario is that the community is faced with a growing medical and health crisis. When the exercise begins, participants must manage the surge capacity and make decisions on the utilization of scarce resources.

November 2003

11-10-03 On Monday evening at 7:00 p.m., there is a free concert that had been planned for months. The event coordinators and sponsors anticipated large numbers of attendees from within and outside of the community. Indeed, the venue was filled to capacity with young and old alike enjoying the fall concert. The event was held indoors in a large building (e.g., gymnasium, arena, enclosed stadium or armory) within the community.

At the end of the event, the cleaning crew finds some devices that look like oxygen tanks near three of the return air vents within the venue. One of the three was still spraying a fine mist into the vent. The device looked "homemade" and none of the cleaning crew knew what the canister was or why it was near the vents.

In their hurry to complete the cleaning of the venue and return home for the night, they placed the canisters in a plastic bag and set them aside. They decided to discuss the canisters with the venue manager on Tuesday morning. The cleaning crew left the venue at 12:30 a.m.

11-11-03 Tuesday morning at 9:00 a.m., the cleaning crew arrives at work. They take the canisters to the venue manager and inform him that they found these canisters next to the return air vents at about 11:00 p.m. the night before. The manager opens the plastic bag containing the canisters and examines them thoroughly. They indeed look "homemade" but harmless to him. Nonetheless, he decides to contact the local law enforcement agency to report the canisters and the event.

11-11-03 Local law enforcement arrives at the venue at 11:00 a.m. to investigate the report from the venue manager, and suspecting foul play, immediately contacts the team within his jurisdiction to respond to a hazardous materials incident.

The haz mat team arrives and contains the canisters safely. Local public health is contacted to assist with examining the canisters and identifying any possible hazard. Samples from the canisters are obtained and sent to the state public health laboratory for analysis. The decision is made to keep this information secure until an agent, if any, can be identified.

BACKGROUND FOR THE SCENARIO
November 2003

11-12-03 A 47-year old female, Jane, a heavy smoker, presents at the hospital emergency department at 6:30 a.m. complaining of a fever (103˚F), shortness of breath and malaise. The patient reports a history of chest pain and cough since Tuesday, November 11. Chest x-ray shows patchy bilateral infiltrates and consolidation. Hemoptysis develops. Lab studies, including blood and sputum cultures, are obtained and antibiotics are started. By noon, her condition deteriorates and she is intubated and placed on mechanical ventilation.

11-12-03 As the day progresses, a large number of patients present to the hospital complaining of high fever, headache, muscle pains, chills and malaise. Emergency Medical Services responders are also reporting an increase in the volume of 911 calls over the last 24 hours.

In the hospital, after triage and treatment, patients with mild symptoms are discharged to home with a working diagnosis of influenza. They are provided symptomatic care instructions to rest and increase their fluid intake, asked to follow up with their private physician in 48 hours if their condition has not improved and asked to return to the emergency department if symptoms worsen. Eight patients with more severe symptoms are admitted to the hospital for care. Two of the patients admitted with severe symptoms requiring intubation are employed as part of the cleaning crew in the local venue.

The hospitals within the county are all reporting high census in the emergency departments and an increased number of inpatient admits with respiratory symptoms. Many hospitals in the area have gone on and off diversion (for emergency department saturation and high inpatient census) frequently in the last 24 hours.

The hospitals contact the Local Public Health Department to report a number of influenza-like cases presenting to the hospitals. Local public health initiates an investigation of the cases and during the contact tracing and history, trace all patients presenting with severe symptoms as having attended the concert on Sunday evening. Local public health contacts the State laboratory to expedite analysis of the agent in the canisters found at the venue on Sunday.

11-12-03 The State laboratory notifies the local health officer at 2:00 p.m. that the agent found in the canisters sent for analysis contained *Yersinia pestis*. The local public health epidemiological investigation and contact tracing confirms that the patients all attended the free concert on Sunday. A local public health emergency is declared and the California Department of Health Services (CDHS) is notified of the emergency. Hospitals, clinics, EMS providers and other healthcare agencies are notified by local public health or designed agency.

11-12-03 As the day progresses, nearly 250 patients with flu-like symptoms have been seen in the emergency departments in the area, and 911 calls in the area continue to increase. Emergency Operations Centers (EOC) open in the county, and local public health is the lead agency. The hospitals activate HEICS, including activation of the hospital EOC. Strict infection control measures are instituted, including respiratory and droplet protection with the N-95 Mask and protective clothing.

BACKGROUND FOR THE SCENARIO
November 2003

11-12-03 Local media hear "rumors" at 6:00 p.m. about a terrorism incident and that many people are becoming ill. They have been monitoring emergency scanners and hear that the EMS calls have been increasing. Media begin to contact hospitals, clinics and other public officials for information. The media announce that there is an event going on in the community and public anxiety increases. Many healthcare providers are calling their employer to express their anxiety about coming to work and being exposed to the disease.

11-12-03 In the hospital, Jane, the heavy smoker who presented to the hospital on November 12, arrests at 9:00 p.m. and efforts to revive her are unsuccessful. She is pronounced dead at 9:02 pm. Her family is distraught and talks to the media upon leaving the facility.

Hospitals and clinics are overwhelmed with large numbers of patients reporting for evaluation and care. Across the county, patients present with flu-like symptoms. The hospitalized patients have developed severe pneumonias, shortness of breath and hemoptysis, and many are requiring intubation. Hospitals are reporting bed availability and requests for additional antibiotics and staffing. The hospitals are reporting numbers of patients being intubated and requiring mechanical ventilation, being treated and released, being treated and admitted and numerous deceased.

Clinics and medical offices are referring the more ill patients to the emergency departments for evaluation and are referring outpatients to the x-ray departments for services. The inpatient census has reached capacity. Respiratory therapy is overwhelmed with requests for respiratory treatments for inpatients and outpatients. There is a shortage of admission beds across the county. The hospital contacts the county EOC for assistance and possible transfer of patients.

The local public health departments activate the mass prophylaxis plan for the community. Multimedia health alerts recommend the following groups of people to present to the mass prophylaxis clinics:

- Those in contact with people who attended the free concert on Sunday and do not have any fever, cough or illness.
- Those who attended the free concert and do not have any fever, cough or illness.

Prophylaxis for pneumonic plague is doxycycline for a seven-day course. Alternative therapy is tetracycline or chloramphenicol. Local public health medication supplies for mass prophylaxis are anticipated to be exhausted by November 14 at noon.

11-13-03 EMS providers report at 6:00 a.m. that they are saturated with 911 calls with a chief complaint of high fever, headache, malaise and cough. Many 911 calls are from the "worried well" asking for information on the "severe flu" as the media have coined it.

BACKGROUND FOR THE SCENARIO
November 2003

11-13-03 Hospitals are reporting at 11:00 a.m. that the high census and lack of resources, including staff, beds, medications and durable medical equipment, especially ventilators, have reached a critical level and assistance is needed.

Many of the hospital and clinic staff have called in sick for their shifts, complicating the resource situation. High census plans are activated in the hospitals and all patients that can be discharged or transferred to alternate care facilities are moved. Negative pressure isolation rooms' capacities are inadequate to meet the patient load. Strict respiratory and droplet isolation is instituted in the facility. There have been 25 deaths reported at this time, and the coroner has been notified to perform autopsies to determine causes of death.

11-13-03 Media from across the state and nation are reporting the biological terrorism event at 2:00 p.m. There are reports from neighboring county health departments that similar cases are being reported in emergency departments and clinics, and strict isolation of the patients is being instituted. The media are arriving at hospitals, clinics, local health departments and governmental agencies demanding information.

Businesses across the local area report high absenteeism because people are afraid to leave their homes. Community alerts are being broadcast on radio and television to provide accurate information to the public.

State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 13, 2003

PARTICIPANT EXERCISE SCENARIO
"The Exercise Begins!"
November 13, 2003
4:00 PM UNTIL 8:00 PM

Note: The exercise begins with the events listed in the background information in the previous section leading up to this point. Participants may recreate the background events and organization status when beginning the exercise to increase realism into the exercise play.

4:00 p.m. THE EXERCISE BEGINS

The Operational Area (OA) is reporting the following statistics:
(Note: Please customize the OA statistics to simulate mass casualty event and capacity overload. Hospitals may also simulate the statistics to meet individual needs for exercise play.)

Statistics for the Operational Area (county):

Number of patients admitted with possible pneumonic plague: _____

Number of patients treated and triaged to home with symptomatic care, including mild symptoms, the worried well and pre-symptomatic patients: _____

Number of patients waiting to be seen: _____

Estimated number of persons that may require mass prophylaxis: _____

Number of deceased: _____

Healthcare resources within the community and operational area have been severely taxed and hospital and clinic are at maximum capacity. Physicians in the emergency department, clinics and medical offices, as well as EMS providers, are requesting information and treatment recommendations for the presenting symptoms of the patients that continue to flow into the system. Information and recommendations being requested include:

- ✓ A case definition
- ✓ Proper isolation for patients presenting with suspected or probable symptoms
- ✓ Personal protective precautions for healthcare staff and first responders
- ✓ Recommended treatment plan

Important questions for the healthcare organization:

Now that *Yersinia pestis* has been identified:

- ☐ How do you identify patients seen in previous days before the biological agent was identified?
- ☐ How do you identify exposed staff?
- ☐ Who within your community/OA can provide your organization with the information and recommendations as listed above?
- ☐ How is this information disseminated to healthcare providers?
- ☐ How is this information disseminated to the public, including media?

4:00 p.m. Healthcare Provider Status

The hospital and clinic emergency plan is activated and the internal emergency operations center (EOC) opened. The county EOC has been activated and the medical and health branch, including the Medical and Health Operational Area Coordinator (MHOAC) continues to call for status reports, bed availability and critical issues.

The intensive care unit(s) within the hospital are at capacity and there are no additional Intensive Care Unit (ICU) beds. The emergency department (ED) is holding a number _____ (insert appropriate number of ED patients to increase strain on resources) of patients awaiting inpatient beds, including ICU, telemetry and medical surgical and negative pressure isolation rooms.

The influx of patients presenting to the ED continues in a steady stream, overwhelming resources, including staff (all levels of healthcare providers), lack of ED space, patient care equipment (gurneys, oximeters, ventilators, oxygen sources) and supplies (medications, patient care supplies) and personal protective equipment (N-95 respirator).

EMS is reporting an increased volume of 911 calls with chief complaint of shortness of breath, cough and fever, requiring transport to the hospital. The hospitals have been on and off diversion; however, now all hospitals are reporting closed status, therefore all hospitals are open. With the volume of 911 calls requiring ambulance transport and high ED and inpatient censuses, EMS providers are greatly delayed in delivering the patient and transferring the care of the patient to the hospital staff upon arrival, resulting in decreased availability of EMS responders to 911 calls.

Clinics are reporting large numbers of patients presenting with complaints of respiratory symptoms and do not have the resources to triage the patients. Patients with severe symptoms must be held in the clinic for long periods of time due to high patient census in the ED and lack of EMS transporters.

Local public health has declared a public health emergency and has determined that mass prophylaxis clinics should be activated to treat the public. Planning for this begins within the health department. Local public health releases alerts to the media to inform and educate the public about the disease symptoms, prevention, when to seek medical care and the availability of mass prophylaxis clinics.

4:30 p.m.

Local public health has announced the case definition for *Yersinia pestis* presenting as pneumonic plague. The case definition and treatment recommendations are:

- Contact with high risk area or person
- High fever (>101.5F)
- Rapid onset of respiratory illness (cough, hemoptysis, shortness of breath)
- Characteristic rash
- Tachycardia, hypotension, sepsis, sudden death
- Chest x-ray findings consistent with pneumonia (bilateral lobar infiltrates)
- Blood and/or sputum cultures positive for gram negative rods
- Serological confirmation of *Yersinia pestis* (DFA)

4:30 p.m.

A van pulls up to the ED ambulance bay with 10 children (all under age 12) and three adults having just returned from a camping trip. They had attended the concert before going camping. As they were returning from the trip, they heard about the plague outbreak on the radio and decided to come immediately to the ED. Five of them are complaining of cough, fever, malaise and abdominal pain. One adult has hemoptysis that began on Wednesday afternoon and one child has diarrhea. They developed symptoms on Tuesday night and have been getting worse and require immediate medical intervention. Five of the 13 people require hospitalization, further stressing already overwhelmed resources.

Considerations for healthcare providers:

- **What isolation control precautions have been taken for providers in all settings, including the hospital ED and inpatient units, clinics and EMS/Ambulance providers?**
- **What type of mask is required for staff caring for infectious patients? Is the N-95 Respirator required or can the staff be protected with standard masks? Who could provide this information to you in your community or from within hospital resources?**
- **Has triage been established to immediately isolate patients presenting with suspicious symptoms from the general population in hospitals and clinics?**
- **Has triage, support and education been established for the "worried well" presenting to the ED, clinics, medical offices and calling EMS providers?**

Healthcare staff, ancillary staff, physicians and EMS providers are beginning to call in sick for the upcoming shifts. While the majority of callers do not report an illness, the staff are anxious and have concerns for themselves and their family members should they be exposed to infectious patients in the course of their duties. Staffing has become critically short and is not anticipated to improve.

The hospital laboratory staff is asking what to do with an overwhelming number of sputum and blood specimens that they are receiving for processing. The lab manager reports this situation as critical and it must be addressed immediately.

Considerations for healthcare providers:

- **What other resources are available to your hospital lab to assist with specimen processing?**

High census plans are activated and all patients assessed for possible discharge or transferred, all elective surgeries and procedures are cancelled (patients have also been calling the hospitals and outpatient surgery clinics to cancel their surgeries because of fear of coming to the hospital).

To respond to the surge of patients, plans to augment staff and maximize current staffing resources are activated, including:

- ✓ Activation of call-back of staff
- ✓ Alteration of shift times, including implementation of 12-16-hour shifts
- ✓ Pre-scheduling staff to alternate shifts (a.m., p.m., noc) to maximize allocation of current resources and ensure 24-hour-a-day staffing

Considerations and possible actions:

- ❑ **Local public health can assist with risk communication messages for the staff and the public to provide information, home care instructions and decrease public anxiety.**
- ❑ **Has the internal public information officer (PIO) and/or liaison officer developed media releases in collaboration with local public health and other healthcare facilities and created a PIO plan?**
- ❑ **Has critical incident stress management (CISM) planning and measures been instituted within the healthcare facility?**
- ❑ **What is the procedure for the healthcare organization/facility to mobilize internal CISM resources to support staff and for contacting local public health and mental health providers for assistance?**
- ❑ **Has mass prophylaxis for healthcare organization staff (hospital, clinic, EMS) and their families been considered in-house?**
- ❑ **Does your facility have the plans and resources needed to provide proper antibiotic prophylaxis for staff, their families and current patients?**
- ❑ **Who in the OA can be contacted to assist with healthcare staffing augmentation for the facilities? (MHOAC can be contacted)**

The decision is made within the hospitals to designate a “wing” or area within the facility to cohort the possibly infectious patients. The following should be considered when designating an isolation area:

Considerations for healthcare providers:

- ☐ **In consultation with the engineering department and infection control, where should the designated isolation area be established?**
  - o **Patient care area**
  - o **Conversion of a non-acute patient care area**
  - o **Isolating patients in alternate care site outside of the hospital facility**
- ☐ **How can the Heating, Ventilation and Air Conditioning (HVAC) be controlled in the designated area to ensure respiratory isolation?**
- ☐ **What special considerations should be taken for the designated area?**
  - o **Security**
  - o **Staff assignment and protection**
  - o **Traffic flow and restriction of personnel, families and friends**

EMS has been transporting potentially infectious patients to the hospitals from homes and clinics across the community.

Considerations for healthcare providers:

- ☐ **What procedures currently exist or must be implemented to decontaminate the ambulances between transports?**
- ☐ **What measures have been taken to protect the ambulance staff during patient assessment and transport?**
- ☐ **Are alternate care sites available for EMS to transport non-acute patients to instead of the acute care facility?**
- ☐ **Has mass prophylaxis for ambulance staff been arranged, and how is this information provided to the staff?**
- ☐ **What measures have been taken to increase staffing and the numbers of available ambulance units in service to accommodate the surge of patients?**

5:00 p.m.

Local public health has established mass prophylaxis clinics in the following locations:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Public alerts are broadcasted on all media, including television, radio and neighborhood meetings to inform the public and decrease anxiety. The local and national media are "camped out" at hospitals and the health department waiting for updates and becoming restless. The media have obtained information that the federal Centers for Disease Control and Prevention (CDC) are enroute and this increases the reports of biological terrorism in the media.

A press conference is scheduled for 6:30 p.m. with the public health officer, appropriate hospital and clinic representatives and local government officials.

Considerations and decisions:

- ❑ **What community or governmental agencies should participate in the press conferences? (Public health, hospital officials, local government, physicians)**
- ❑ **Who is the most appropriate person(s) to represent the healthcare facility at the press conference(s) and who makes this decision?**
- ❑ **How often should the press conferences be scheduled?**
- ❑ **Where should the press conferences be convened within the community?**
- ❑ **Who is the "lead" agency for the press conferences?**
- ❑ **What steps have been taken to ensure a consistent message among the healthcare community and all levels of government agencies/officials?**

5:45 p.m.

The hospitals, clinics and EMS providers are experiencing a shortage of equipment, supplies and facilities to care for patients. The shortages will be critical within 12 hours, including the following essential items:

N-95 Masks and other respiratory protective equipment
Ventilators
Oxygen tents to accommodate pediatric patients.
Antibiotics
Isolation facilities
Morgue facilities
Beds, gurneys, cots
Healthcare providers and staff support personnel

Hospitals, clinics, EMS and local public health construct contingency plans to address the upcoming critical shortages. Vendors are contacted to provide the additional supplies and equipment, but the vendors state that they will not deliver to the facility due to possible exposure of the delivery personnel.

Many patient deaths have been reported at the hospitals and the hospital morgue resources have reached capacity. The deaths are considered medical examiner's (coroner's) cases and potential evidence in a biological terrorism incident.

Considerations and possible actions:

- **Activate current processes and procedures to procure essential resources needed currently and within 12 hours?**
- **If no processes or procedures exist, what possible actions and plans can be taken to procure the resources?**
- **Can vendors be protected from exposure or provided prophylaxis to ensure delivery of needed resources?**
- **What resources and mechanisms are available to procure the needed supplies and equipment and who or what agency is contacted to provide those resources?**
  - **Intra-hospital resources**
  - **Inter-hospital resources**
  - **Community resources, including city and county**
  - **County resources, including the MHOAC in the EOC**
  - **Others**
  - **What are the proper channels of communication and who or what agency is contacted to obtain those resources**
- **What non-medical resources may be needed in the event? (i.e. security, law enforcement, sanitation, water, transportation)**

6:30 p.m.

The press conference begins.

6:45 p.m.

The press conference has spurred an overwhelming number of phone calls, both landline and cellular coming into and going out of the community. Local phone lines and cell sites are unable to accommodate the surge of calls and the phone systems go down. The hospitals, clinics, EMS providers and public health and county EOC are unable to place or receive calls.

Auxiliary Communication Systems (ACS) plans are activated. Local ACS members respond to provide critical communications as per current plans and procedures. If no plans or procedures exist, what emergency plans can be instituted to address the communication crisis?

7:00 p.m.

Local, state and federal law enforcement are arriving at the healthcare facilities and local health department. They are requesting to immediately interview staff, patients and families and to take possession of any evidence, including medical records.

- ✓ What issues does this pose to the healthcare facility, staff, patients, local public health and others?
- ✓ What policies and procedures are in place to guide and direct staff when handling these requests?
- ✓ If no policies currently exist, what emergency planning can be done to address these issues?
- ✓ How will law enforcement personnel interviewing patients be oriented to personal protection/isolation precautions?

7:15 p.m.

Phone service has been reestablished in the area. However, the phone company has stated that service may be intermittent due to volume. What decisions should be made about maintaining the ACS communication functions?

7:30 p.m.

All facilities, agencies and providers report status to the OA. The OA and EOC compile the reports, enter information into RIMS and place mission requests as appropriate.

7:45 p.m.

The Regional Emergency Operations Center (REOC) begins to receive reports from the OA and relays the information and resource requests to the Joint Emergency Operations Center (JEOC) and the State Operations Center.

8:00 p.m. THE EXERCISE ENDS

State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 13, 2003

Glossary of Terms

Auxiliary Communications Services (ACS)	The Auxiliary Communications Service (ACS) is an emergency communications unit that provides State and local government with a variety of professional unpaid [volunteer] skills, including administrative, technical and operational for emergency tactical, administrative and logistical communications. ACS works with agencies and cities within the Operational Area, neighboring governments and the State OES Region. Its basic mission is the emergency support of civil defense, disaster response and recovery with telecommunications resources and personnel. **CARES: California Amateur Radio Emergency Services** CARES is specifically tasked to provide amateur radio communications support for the medical and health disaster response to state government. **RACES: Radio Amateur Civilian Emergency Services** RACES is a local or state government program established by a civil defense official. It becomes operational by: 1) appointing a radio officer; 2) preparing a RACES plan; and 3) training and utilizing FCC licensed amateur radio operators. RACES, whether part of an ACS or as a stand alone unit, is usually attached to a state or local government's emergency preparedness office or to a department designated by that office, such as the sheriff's or communications department.
Bioterrorism	The intentional or threatened use of viruses, bacteria, fungi or toxins from living organisms to produce death or disease in humans, animals or plants.
Cohorting	Co-locating a group of persons (patients) experiencing similar symptoms or disease syndrome to provide medical care and/or isolation.
Disease Surveillance	In epidemiology and public health, the identification of index patients and their contacts; the detection of outbreaks and epidemics; the determination of the incidence and demographics of an illness; and the policy-making that may prevent further spreading of disease.

Glossary of Terms

Droplet Transmission And Isolation	**Transmission:** Droplet transmission involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets (larger than 5 µm in size) containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism. Droplets are generated from the source person primarily during coughing, sneezing or talking and during the performance of certain procedures, such as suctioning and bronchoscopy. Transmission via large-particle droplets requires close contact between source and recipient persons because droplets do not remain suspended in the air and generally travel only short distances, usually three feet or less, through the air. Since droplets do not remain suspended in the air, special air handling and ventilation are not required to prevent droplet transmission. **Droplet Isolation:** Place the patient in a private room. When a private room is not available, place the patient in a room with a patient(s) who has active infection with the same microorganism but with no other infection (cohorting). When a private room is not available and cohorting is not achievable, maintain spatial separation of at least three feet between the infected patient and other patients and visitors. Special air handling and ventilation are not necessary, and the door may remain open. Category IB
Emergency	A condition of disaster or of extreme peril to the safety of persons and property caused by such conditions as air pollution, fire, flood, hazardous material incident, storm, epidemic, riot, drought, sudden and severe energy shortage, plant or animal infestations or disease, earthquake or volcanic eruption.
Emergency Management	The organized analysis, planning, decision making, assignment and coordination of available resources to the mitigation of, preparedness for, response to or recovery from emergencies of any kind, whether from man-made attack or natural sources.
Emergency Operations Center	A centralized location from which emergency operations can be directed and coordinated.
Epidemic	An infectious disease or condition that attacks many people at the same time in the same geographical area.
Epidemiology	The study of the distribution and determinants of health-related states and events in populations, and the application of this study to the control of health problems. Epidemiology is concerned with the traditional study of epidemic diseases caused by infectious agents, and with health-related phenomena.
Exposure Versus Contamination	**Exposure**: Subjected to, or exposed to, a contaminant in an unprotected or partially protected manner, but not necessarily contaminated by an agent. **Contamination**: Contact with a hazardous or infective agent in an unprotected manner.

Glossary of Terms

Exercise	**Functional:** The functional exercise is an activity designed to test or evaluate the capabilities of the disaster response system. It can take place in the location where the activity might normally take place, such as the command center or incident command post. It can involve deploying equipment in a limited, function-specific capacity. This exercise is fully simulated with written or verbal messages. **Full Scale:** This type of exercise is intended to evaluate the operational capability of emergency responders in an interactive manner over a substantial period of time. It involves the testing of a major portion of the basic elements existing in the emergency operations plans and organizations in a stress environment. Personnel and resources are mobilized. **Tabletop:** An exercise that takes place in a classroom or meeting room setting. Situations and problems presented in the form of written or verbal questions generate discussions of actions to be taken based upon the emergency plan and standard emergency operating procedures. The purpose is to have participants practice problem solving and resolve questions of coordination and assignment in a non-threatening format, under minimal stress. **Communications:** The communications exercise is designed to test and evaluate communication systems, including lines and methods of communicating during a disaster. Alternative communication systems can also be tested, including amateur radio, cell and satellite systems, among others.
Hospital Emergency Incident Command System (HEICS)	HEICS is an emergency management system that employs a logical, unified management (command) structure, defined responsibilities, clear reporting channels and a common nomenclature to help unify hospitals with other emergency responders. Information on HEICS can be obtained through the California EMSA at 916-322-4336 or on the Website at www.emsa.ca.gov.
Incident Command System (ICS)	The nationally used standardized on-scene emergency management concept is specifically designed to allow its user(s) to adopt an integrated organizational structure equal to the complexity and demand of single or multiple incidents without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures and communications operating within a common organizational structure, with the responsibility of managing resources to effectively accomplish stated objectives pertinent to an incident.

Glossary of Terms

Fit Testing	All respirators that rely on a mask-to-face seal need to be annually checked with either qualitative or quantitative methods to determine whether the mask provides an acceptable fit to a wearer. The qualitative fit test procedures rely on a subjective sensation (taste, irritation, smell) of the respirator wearer to a particular test agent while the quantitative fit test measures face seal leakage. The relative workplace exposure level determines what constitutes an acceptable fit and which fit test procedure is required. (OSHA 29 CFR 1910.139)
Incubation Period	The interval between exposure to infection and the appearance of the first symptom.
Index Patient	An instance of a disease or a genetically determined condition that is discovered first and leads to the discovery of others in a family or population.
Isolation	The physical separation of infected or contaminated organisms from others to prevent or limit the transmission of disease. In contrast, quarantine applies to restriction on healthy contacts of an infectious agent.
Joint Emergency Operations Center (JEOC)	A unified operations center established by the State Emergency Medical Services Authority and Department of Health Services to manage the State-level medical and health response to disasters, including the use of state resources.
Long-Term Care Facilities	A collective term for healthcare facilities designated for the care and treatment of patients or residents requiring rehabilitation or extended care for chronic conditions. The Department of Health Services, Licensing and Certification Division licenses these facilities.
Mass Prophylaxis	The provision of medications and/or vaccines to large numbers of the public to prevent or treat an infectious disease.
Medical and Health Operational Area Coordinator (MHOAC) **(Formerly known as OADMHC)**	The OAC is responsible for coordinating mutual aid resource requests, facilitating the development of local medical/health response plans and implementing the medical/health plans during a disaster response. During a disaster, the OAC directs the medical/health branch of the Operational Area EOC and establishes priorities for medical/health response and requests. This coordinator was formerly known as the Operational Area Disaster Medical/Health Coordinator.
N-95 Mask	See “Respirator, N-95”
Operational Area	An intermediate level of the State emergency services organization, consisting of a county and all political subdivisions within the county.
Pandemic	A disease affecting the majority of the population of a large region, such as dental caries or periodontal disease, or one that is epidemic at the same time in many different parts of the world.

Glossary of Terms

Plague	A disease caused by *Yersinia pestis (Y. Pestis)*, a bacterium found in rodents and their fleas in many areas around the world. Plague may present in two forms: Bubonic, which is spread by flea bites and results in swollen, tender lymph nodes called buboes; and Pneumonic, which affects the lungs and is transmitted when a person breathes in *Y. Pestis* particles in the air.
Quarantine	The period during which free entry to a country by humans, animals, plants or agricultural products is prohibited in order to limit the spread of potentially infectious diseases; the period of isolation from public contact after contracting a contagious disease, such as rabies. Complete quarantine is the limitation of the freedom of movement of healthy persons or domestic animals that have been exposed to a communicable disease for a period of time equal to the longest incubation period of the disease, in such a manner as to prevent effective contact with those not so exposed.
Regional Emergency Operations Center (REOC)	The Regional Emergency Operations Center (REOC) is the first level facility of the Governor's Office of Emergency Services to manage a disaster. The REOC provides an emergency support staff operating from a fixed facility, which are responsive to the needs of the operational areas and coordinates with the State Operations Center.
Respirators N-95	Recent CDC infection control guidance documents provide recommendations that health care workers protect themselves from diseases potentially spread through the air (such as Severe Acute Respiratory Syndrome or Tuberculosis) by wearing a fit-tested respirator at least as protective as a National Institute for Occupational Safety and Health (NIOSH)-approved N-95 respirator. An N-95 respirator is one of nine types of disposable particulate respirators. Particulate respirators are also known as "air-purifying respirators" because they protect by filtering particles out of the air you breathe. Workers can wear any one of the particulate respirators for protection against diseases spread through the air- if they are NIOSH approved and if they have been properly fit-tested and maintained. NIOSH-approved disposable respirators are marked with the manufacturer's name, the part number (P/N), the protection provided by the filter (e.g. N-95) and "NIOSH."
Standardized Emergency Management System (SEMS)	SEMS is the emergency management system identified by Government code 8607 for managing emergency response to multi-agency or multi-jurisdictional operations. SEMS is based on the Incident Command System and is intended to standardize response to emergencies in California.
State Operations Center (SOC)	The SOC is established by OES to oversee, as necessary, the REOC, and is activated when more than one REOC is opened. The SOC establishes overall response priorities and coordinates with federal responders.

State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 13, 2003

Operational Area (County) Medical/Health Exercise Contacts

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Operational Area (County) Medical/Health Exercise Contacts

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Operational Area (County) Medical/Health Exercise Contacts

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Operational Area (County) Medical/Health Exercise Contacts

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Operational Area (County) Medical/Health Exercise Contacts

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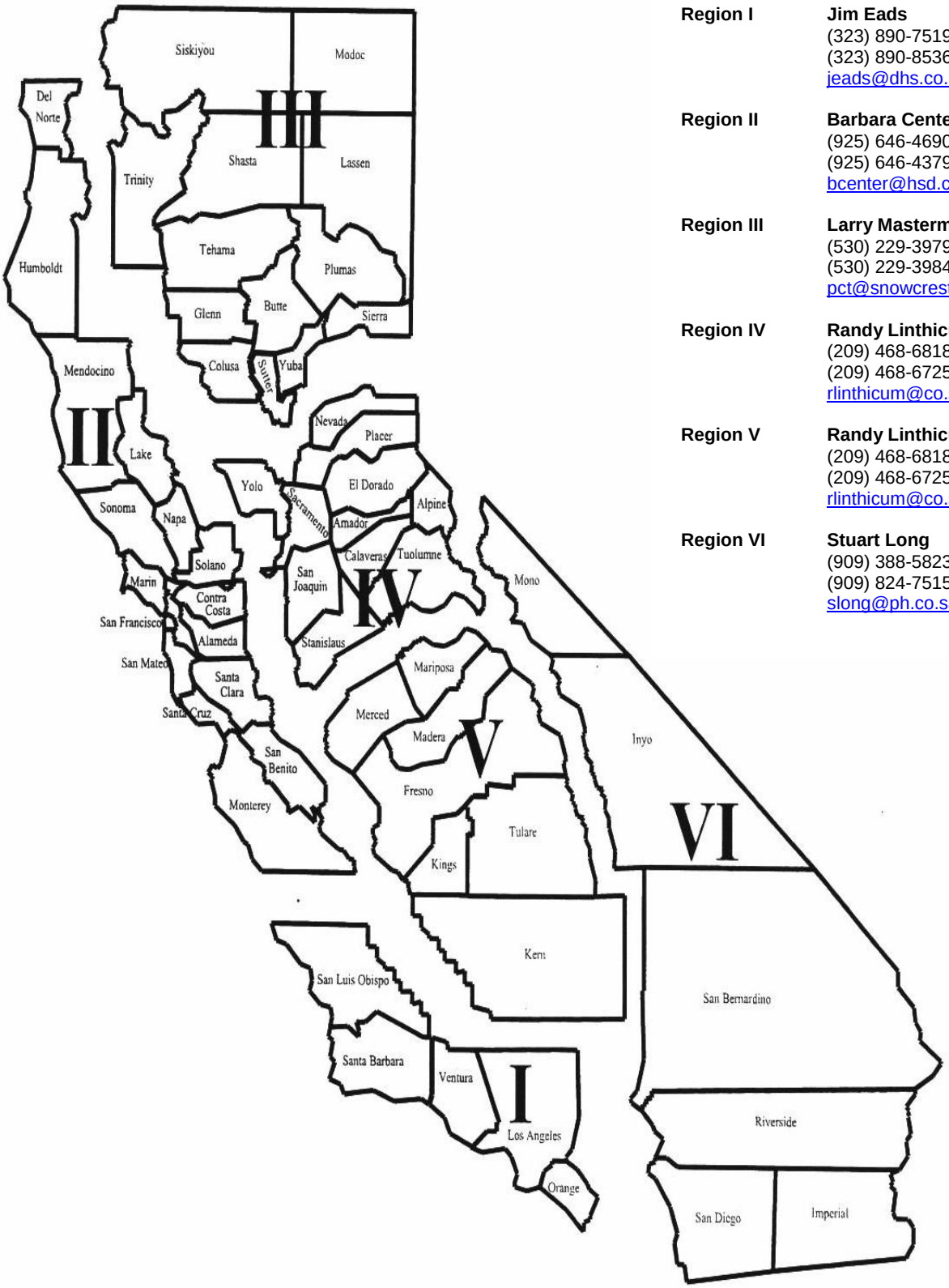
OES Mutual Aid Regions



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State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 13, 2003

Exercise Participant Evaluation

"Hotwash"

After-Action Debriefing

This is a suggested list of questions recommended for incorporation into the debriefing or "hotwash" for the exercise participants. Please elicit as much detail as possible and compile the information.

It is recommended to appoint one person to conduct the debriefing and to moderate as required. A scribe can be directed to track and document comments and recommendations made by the participants during the hotwash. The Operational Area (County) Disaster Medical/Health Exercise Contact, or designee, should compile and submit the hotwash information to the Regional Disaster Medical/Health Specialist (RDMHS) during a regional hotwash to be announced at a later date.

It is suggested to schedule the operational area debriefing as soon as possible after the exercise.

Debriefing Questions

1. Was the information contained in the Disaster Exercise Guidebook clear and concise? What changes/additions would you suggest?

2. Was the "Intent to Participate" form user friendly? Would you suggest any additions or deletions?

3. Were the "Exercise Objectives" clear and applicable to a potential real life situation?

4. Was the "Exercise Scenario" realistic, useful and clear?

5. Did you change or expand the exercise scenario to meet the needs of your facility? If so, how?

6. What items/sections of the Disaster Exercise Guidebook were not helpful?

7. Any suggestions for improvement in any of the items or sections of the Disaster Exercise Guidebook?

8. Were the pre-exercise time frames/expectations reasonable? What would you do differently?

9. Did you test communication systems?

   a. Did you use an alternative communication system during the exercise (i.e. ACS)?
      If yes:
      i. Describe the benefits and/or problems with data transmission via ACS radio.
      ii. Were two-way messages sent and received?
      iii. Was the specific information requested from hospitals, ambulance providers and others useful?
      iv. What would you add/delete?
      v. How would you resolve any problems or issues in the future?

   b. Did you use other communication technologies during the exercise (i.e. fax, email, internet, etc.)?

      If yes: What were the benefits and what worked well?
      What did not work well, what problems or issues did you have?
      How would you resolve any problems or issues in the future?

10. Describe the use of the Response Information Management System (RIMS) in your county.

   a. Where and by whom was the information entered into RIMS?
   b. Was the information requested from the hospitals pertinent to the situation and helpful to you?
   c. Will the overall medical/health information requested on the RIMS forms be pertinent in a real life situation?
   d. What suggestions would you offer for revisions to the medical/health RIMS data?
   e. What training, administrative or logistical issues need to be addressed?

11. If the Operational Area's Emergency Operations Center was activated:

   a. Was the interaction with disaster management officials at the operational area's EOC useful and provide you with direction, information and assistance?
   b. Describe your interaction with the EOC in your operational area.
      i. What worked well?
      ii. What could be improved?

12. What training issues or points did you identify during the exercise that needs to be addressed before the next exercise/actual event?

13. Was the Exercise Contact Toolkit helpful?

   a. Did you utilize the Toolkit in preparing for the Exercise?
   b. How could the Toolkit be improved next year?

14. Any other issues or items for the debriefing?

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The Emergency Medical Services Authority would like to thank the Disaster Exercise Planning Committee members for their planning and contributions to the 2003 Statewide Medical and Health Disaster Exercise Guidebook.

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